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ABSTRACT

This paper explores the findings and current state of research on the familial characteristics of persons with borderline personality disorder (BPD). A review of the borderline personality disorder emphasizes the development of the term, etiological issues, and treatment issues related to BPD. Two formal approaches for obtaining accurate diagnosis with a borderline patient are noted. Three major areas of familial characteristics are identified. First, the familial transaction patterns of borderline patients are examined, including the issues of separation and autonomy with the BPD family. Studies are reviewed which suggest that the family environment of the borderline patient does not provide for normal developmental needs in the areas of both nurturance and autonomy. Second, research on the family transmission of BPD is reviewed, including research on both the genetic and the social transmission of the disorder. The final area discussed concerns psychiatric disturbances among family members of BPD individuals. Research is presented which indicates that family members of borderline patients often suffer from significant affective or characterological disturbances. It is noted that the current status of the research suggests that, in a variety of ways, the borderline patient is part of a disturbed family milieu. The need for recognition of the impact of the family system on functioning and treatment is discussed in light of the findings. (NB)

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# FAMILIAL CHARACTERISTICS OF INDIVIDUALS WITH BORDERLINE PERSONALITY DISORDER DIAGNOSIS

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Doctoral Research Paper
for the Degree of Doctor of Psychology

ROSEMEAD SCHOOL OF PSYCHOLOGY

BIOLA UNIVERSITY

JAMES LAWRENCE BERNHARDT

1986

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# FAMILIAL CHARACTERISTICS OF INDIVIDUALS WITH BORDERLINE PERSONALITY DISORDER DIAGNOSIS

BY

JAMES LAWRENCE BERNHARDT

A doctoral research paper submitted to
Rosemead School of Psychology
in partial fulfillment of the requirements
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1986

FAMILIAL CHARACTERISTICS OF INDIVIDUALS WITH

BORDERLINE PERSONALITY DISORDER DIAGNOSIS

BY

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FAMILIAL CHARACTERISTICS OF INDIVIDUALS WITH
BORDERLINE PERSONALITY DISORDER DIAGNOSIS

BY

JAMES LAWRENCE BERNHARDT

The borderline patient presents a challenging therapeutic picture to the mental health professional. This paper reviews the growing body of empirical study which has observed the familial characteristics of this treatment population. Specifically, three areas are identified; 1) The familial transactions of borderline patients. 2) The familial transmission of borderline personality disorder. 3) The broader pattern of psychiatric disturbance among the family members of identified borderline patients. The current status of the research in this area suggests that, in a variety of ways, the borderline patient is part of a disturbed family milieu. The need for recognition of the impact of the family system on functioning and treatment is discussed in light of the findings.

## Familial Characteristics of Individuals with Borderline Personality Disorder Diagnosis

Within the field of clinical psychology the term "borderline" often presents the clinician with a confusing diagnostic and therapeutic picture. There has been debate regarding the etiology, treatment and even the distinct existence of the borderline personality disorder (BPD). The publication of the DSM-III in 1980 provided recognition and shared communication among mental health professionals regarding this disorder. The DSM-III suggests a variety of cognitive, emotional and interpersonal characteristics which reflect the difficult adjustment of many borderline individuals.

Recognition and acceptance of the BPD as a distinct characterological disturbance has come with an increasing body of empirical study. Issues such as diagnosis, prognosis, and treatment have been the emphasis of a major portion of the research literature. In addition, a growing body of empirical study has focused on the familial characteristics of the borderline individual. This study has moved our clinical understanding beyond the more narrow intrapsychic focus to a broader perspective of issues related to the interpersonal functioning of the borderline personality disorder individual. In many ways, this is a

recent area of research emphasis. Gunderson, Kerr and Englund (1980) addressed this in their study of borderline families:

> Many of the psychopathological characterisitics of borderline patients have commonly been believed to be traceable to environmental and, more specifically, family disturbances. Despite this, and despite the fact that dynamic, interactional and experiential studies of family functioning have become so popular and influential during the past fifteen years, the families of borderlines have largely been ignored as a research subject. (p. 59)

Theoreticians and researchers have begun to take note of the family environment of borderline patients as a significant factor in personality development. For instance, family therapists Schwoeri and Schwoeri (1980) have suggested that borderline pathology is not confined to one member but is part of the family system's interactional pattern. Mandelbaum (1980) also articulated the familial plight of many borderline patients when he related, "I believe that most borderline patients are involved in a family system which prevents them from further development and which makes the possibility of change not only difficult but hazardous." (p. 37)

The purpose of this paper is to explore the findings and current state of research on the familial characteristics of borderline individuals. This is done with the basic understanding that thorough and effective

intervention, whether on an individual or familial level, is enhanced by a clear perspective of the intrapsychic and interpersonal dynamics of the situation. Focus will be given to the family transactions characteristic of many borderline patients. We will also observe the frequent existence of psychiatric disturbances among the family members of borderline individuals. In addition, literature which studies the familial transmission of borderline personality disorder will be reviewed.

## Borderline Personality Disorder

Prior to a discussion of the research on the family characteristics of the borderline patient, we will begin with a review of the borderline personality disorder, with emphasis on the development of the term, etiological issues and treatment issues related to this disorder.

### Development of the Term

In general, the historical perspective on the BPD has pointed to the attempt to classify a group of patients functioning at a psychological level somewhere between neurosis and psychosis. In his review of the development of the BPD diagnosis, Goldstein (1983) credits Stern (1938) as being the first person to formally use the term "borderline." "Ambulatory schizophrenia", Pseudoneurotic schizophrenia", "Latent psychosis", and "Psychotic character" are also identified

by Goldstein as early attempts to describe and classify those patients who in today's terminology would likely be characterized as BPD.

Kernberg (1975) has become a leading voice in the present day study of borderline personality. His work has done much to integrate the psychodynamic perspective on BPD and provide a formalized understanding of this disorder. Kernberg views the structure of the borderline personality as one of three distinct levels of intrapsychic structuralization, the other two being that of the neurotic and that of the psychotic. The borderline personality is distinguished for Kernberg by a unique set of ego strengths and weaknesses. In this sense, Kernberg offers a broader perspective on the borderline personality than that described in the DSM III. In other words, Kernberg's borderline personality is a superordinate term which could be applied to individuals diagnosed with a variety of characterological or affective disorders. Ego strengths suggested by Kernberg to be characteristic of the BPD are: 1) The relative intactness of reality testing. 2) The relative intactness of thought processes. 3) The relative intactness of interpersonal relations. 4) The relative intactness of adaptation to reality. In Kernberg's presentation of the borderline patient, these four characteristics clearly differentiate the borderline patient

from the psychotic and allow in a general sense, for the presentation of a "normal" personality. In addition, however, Kernberg suggests several ego weaknesses related specifically to the borderline personality: 1) The combination of poor impulse control and poor frustration tolerance. 2) The proclivity to use primitive ego defenses. 3) The syndrome of identity diffusion. 4) The characteristic of affective instability. These ego weaknesses, usually recognized only with a detailed examination of the patient's history, differentiate the borderline patient from the neurotic, according to Kernberg.

Etiology

A variety of theoreticians have considered the etiological issues associated with the development of BPD. The work of Campbell (1982) is helpful in providing an understanding of the major theoretical positions on the development of BPD. In this author's discussion of the psychotherapy relationship with the BPD, she outlines the developmental perspective of a variety of clinical thinkers (Kernberg, Blanck & Blanck, Masterson, Searles, Goldberg, Giovacchini, Zetzel, Adler, Little, and Rosenfeld). Campbell points to the broad agreement among these theorists that the borderline character structure represents early deficits in the parent-child

relationship. As she states:

> There is general agreement among the ten theorists that borderline disorders are characterized by a preoedipal developmental arrest in which adequate achievement of the separation-individuation process has not occurred. The reasons for this arrest are seen by all the theorists as inadequacies in the early mother-child relationship which prevented the child from progressing or led her/him to progress with a limited or defective character structure and defensive operations (p. 181)

The separation-individuation process was formally developed in the work of Margaret Mahler (1975). Based upon her longitudinal study of mother-infant interactions, Mahler suggested three phases during the first three years of life which characterize the infant's development of a sense of self and separateness from the maternal figure. The phase of Absolute Autism (0-2 mths.) is characterized by the life sustaining use of a reflex activities without mental representations. Mahler suggests that the biological "pleasure principle" prevails at this stage of development. "Good" is that which reduces tension and "bad" is that which increases or fails to reduce tension.

In the phase of Symbiosis (2-6 mths.), Mahler's developmental schema suggests that there is essentially no distinction between the infant's very primitive sense of self and a dim awareness of the mother as a feeding object. In a very basic sense, the infant perceives him/herself and the mother as one.

The final developmental phase of Separation-Individuation is characterized by the rapid development of the infant's motor and sensory skills. During this phase, the infant gradually experiences the maternal figure as a separate person. Healthy parenting involves encouragement of the child's need to explore and move towards independance while providing safety and protection when necessary.

The theoreticians reviewed by Campbell suggest that the borderline individual experienced significant deficits during this developmental process. Specifically, it has been argued that the borderline individual's normal developmental process of moving from a dependant to an independant stance is impeded through poor parenting. This was the position of Rinsley in his text on the severely disturbed adolescent:

> Masterson and I (Chapter 12) have traced the etiology of borderline personality disorder to a to a particular pattern of mother-infant interaction originating in the early separation-individuation phase and reaching its peak during the rapprochement subphase. We have postulated that the mother of the future borderline child and adult, herself borderline, rewards (provides libidinal supplies and gratification to) her infant when he behaves in a dependent, clinging manner toward her, but threatens to reject or abandon (withdraw libidinal supplies and gratification from) him when he makes efforts toward being independent of her, that is toward separation-individuation. Thus, the infant (later the borderline individual) comes to perceive that independence, growth, and autonomy lead only to abandonment, while remaining symbiotically dependent guarantees the flow and acquisition of

> necessary support and supplies, albeit at the ultimate and disastrous expense of healthy independence and autonomy. Thus, the borderline individual's double bind: to remain infantile is to retain the mother and her love, to grow is to lose them (the ultimate meaning of the term loser). (p.290)

In light of a broad group of theoreticians who point to early parent-child disturbances as key in the development of borderline pathology, a review of the research on familial characteristics of borderline patients appears particularly pertinent. It is hoped that the present review will aid in the attempt to discern family characteristics or family behavior patterns which may be contribution factor to BPD.

## Intervention with the Borderline Personality Disorder

The cognitive, emotional and social functioning of the BPD present a challenging diagnostic and treatment picture.

Effective treatment begins with accurate diagnosis. The BPD may often present for psychotherapy with a variety of diffuse symptoms making accurate diagnosis a difficult undertaking. Two formal approaches to obtaining accurate diagnosis with a borderline patient are noted. Kernberg (1977) advocates an approach which focuses on the structural development of the patient. His Structural Interview, for use with possible borderline patients, attempts to understand the patient's structural

development in terms of reality testing, defensive functioning and identity diffusion. The goal of the interview is to obtain a differential diagnosis among the neurotic, psychotic, and borderline categories.

A second, frequently used diagnostic approach with borderline patients has come out of the work of Gunderson and Singer (1975). These authors reviewed the descriptive literature on borderline patients and identified six features which provided means for diagnosing borderline patients during an initial interview. These features were: the presence of intense affect, usually depressive or hostile; a history of impulsive behavior; a certain social adaptiveness; brief psychotic experiences; loose thinking in unstructured situations; and the relationships which vacillate between transient superficiality and intense dependance. The Diagnostic Interview for Borderlines is a semi-structured interview technique developed by Gunderson, Kolb, and Austin (1981). This technique was based largely upon the initial review of Gunderson and Singer and has become a frequently used tool, particularly in research with a borderline population. The Diagnostic Interview places major emphasis upon the history of the patient while Kernberg's interview technique is more process-oriented relying substantially on the interpersonal experience of the therapist with the client.

Treatment Issues with Borderline Patients

In light of the intrapsychic and interpersonal characteristics of the borderline patient, it is not surprising that the BPD often presents a difficult treatment picture to the clinician. The borderline patient can often be very taxing emotionally to the psychotherapist. Goldstein (1983) described the boderline patient thusly, "There is an inability to delay, a demand for immediate gratification, and proclivity to act out under stress. To make matters more difficult, these characteristics are not infrequently combined with a sense of entitlement." (p.316)

Much of the dialogue in the clinical literature has focused on the transference and countertransference issues associated with the treatment of the BPD. Searles (1979) has noted that the therapist often feels, "like an unwanted child" (p.329) in relation to the borderline patient. He suggests that the therapist may come to feel toward the patient the way the patient felt towards his or her own mother. Schwoeri and Schwoeri (1981) describe the extreme "oral neediness" of the borderline patient which often leads to impatience and rage that the therapy is not producing instantaneous magical results. They note that this can lead to an avoidance or abandonment of the patient in overt or covert ways by the therapist. Masterson (1976) has noted the frequent efforts of

borderline patients to push the therapist into a position in which he or she finally reacts with counteraggression, e.g. going from good and giving parent to withholding and uncaring within moments in therapy.

Our current understanding of developmental issues as well as diagnostic and treatment issues with the BPD suggest the need for a thorough understanding of this characterological disorder. It is hoped that the present review of the familial issues associated with BPD will enhance both understanding and intervention.

Familial Transaction Patterns of Borderline Patients

Empirical study of the family transactions of borderline patients has contributed to our understanding of the interpersonal patterns which characterize many borderline families. Theoretical issues, such as Mahler's concept of separation and individuation have been observed in the family transactions of borderline patients of a variety of ages. Study of the family transactions of borderline patients has also broadened our understanding of the possible sources of the development of BPD beyond simply the mother-child relationship to the family unit as a whole.

Mandelbaum (1980) has suggested that many of the characteristics and patterns of behavior in families of borderline patients represent the patient's desperate

attempts to keep the family's structure in equilibrium. These characteristics are: 1) Marital relationships are often quite troubled and block both spouses from exerting effective parental leadership. 2) Parents have great difficulty in agreeing on what should be the family policy for the children and there are competitive fights for control. 3) Both spouses are deeply enmeshed with their families of origin. They may have a distant relationship with their parents but not one which is differentiated and autonomous. 4) There is often a high incidence of trauma experienced in early childhood through the early death of a parent, divorce, suicide or alcoholism. 5) Boundaries between the spouses in their roles of husband and wife and in their roles as parents become too easily blurred and are therefore easily trespassed. 6) Boundaries between parents and children also tend to be blurred, with some children invading parental functions and the parents invading the privacy of their children. 7) There is the likelihood of finding several generations of family matrices in which individuals, easily labeled as good and bad, have serious difficulties in interpersonal relations, lack of empathy, and failures in the attempts to emancipate from the primary figures in family life. Mandelbaum's characterization of the borderline family is based upon his clinical case studies, and his discussion should be looked at in light

of the limitations of case studies, e.g. the lack of a control group or consistent measures.

The perspective of family therapists Schwoeri and Schwoeri (1981) suggest further transaction characteristics in the borderline patient's family. Based upon their clinical work with court and police referred adolescents, these authors also point to several general characteristics: 1) Parents present strongly held projections which are upheld and verified by other family members. 2) There is a bland acceptance of violence among family members. 3) There is an extreme and persistent reversal of parent-child roles. 4) The family experiences a lack of parental rules and discipline. 5) There is a tendency in the family to employ the defense of splitting, usually manifested by one parent being angry at one of the children and pleased with the others. In the review that follows, we will see that their understanding is often supported by empirical research.

One method which has been used to study the family transactions of borderline patients has been the retrospective recall of the patients. Snyder, Pitts, Goodpaster, and Gustin (1984) attempted this with a predominately male (24 male, 2 female) inpatient adult borderline population. Subjects were administered the

Developmental and Social History (DASH) questionaire which measures the patient's self-perceptions in six areas of functioning: 1) Demographic information. 2) Present psychiatric problem. 3) Psychiatric history of illness. 4) Family history, including the nature of family interpersonal relationships. 5) Developmental history. 6) Adulthood. This instrument includes a series of questions to which the subjects respond with choices ranging from "no information/never" to "very frequent/ severe." Results of this study indicated that the male parental figure was perceived as more dominant than the female parental figure. In addition, female parental figures were perceived by the patients as significantly more affectionate toward him or her. A further significant finding of this study was a perceived change in family relations at different ages of the patient. Specifically, the patient perceived significantly less closeness and more conflict in the family as they grew older. The borderline subjects reported close family relations between the ages of three and five with significantly more conflict perceived in the post latency (after age 11) period. Recreational activity by the family group as a unit was noted to be a rare occurrence by the borderline patient.

The efforts of Snyder, Pitts, Goodpaster, and Gustin

(1984) point to a borderline family picture in which adult borderline patients recall having received more affection from the maternal figure and have experienced an increased amount of family conflict as they grew older. One could hypothesize that increasing family conflict may be related to the separation and autonomy issues experienced by borderline individuals, yet the findings of this study should be evaluated in light of several methodological issues. A major concern with this work is the lack of any type of control population, leaving it difficult to conclude that findings are related specifically to the borderline home situation. The predominately male subject pool also limits the generalizability of this work. In addition, reliance on the subjective reports of patients limits the objectivity of the measurement. Findings may be significantly impacted by the distortions or difficulty in accurate recall by the subjects.

A self-report study on borderline patient's recollections of family experience was also undertaken by Hallie and Paris (1981). In this study, female borderline patients were asked whether they remembered their mothers and fathers as having responded with approval, disinterest or criticism to dependent and independent behaviors. Comparison was made with a group of normal controls, with a group of neurotics and with a group of patients with other

personality disorders. The patient sample for this study was drawn primarily from students engaged in long-term psychotherapy at a college counseling center. The measurement instrument used in this study, the Childhood Experience Scale, was designed by the authors. Each of the ten items on this scale asks which of the three possible reactions (approval, disinterest, or criticism) would best characterize the recollected parental response. Examples of the items would be, "Disappointment with failure to achieve", and "Desire to have friends outside the family."

The results in this study indicated that the control subjects (considered jointly) to have been more supportive and less disinterested than the fathers of neurotics, personality disorders, or the normal controls. As with the Snyder et al. study, this work points to a generally nonsupportive family environment as experienced by the borderline individual.

The addition of control groups to this study contributes to the strength of the findings. The all female patient sample limits it's application to a broader population however. In addition, the Childhood Experience Scale represents a very novel measurement instrument which limits the validity of the findings. Further replication using this particular instrument, as well as further study

pertaining to it's reliability and validity is necessary to it's continued use as an effective research tool.

The work of Gunderson et al. (1980) which was quoted earlier in this paper, represents a further attempt to discern characteristics within the borderline's family. This study was based on a review of extensive family evaluations for a young adult (15 to 24 years) inpatient population. Three groups of subjects were reviewed: borderline (n=12), paranoid schizophrenic (n=12), and hospitalized neurotics (n=12). Material was obtained about the family of each patient based upon a variety of sources; social work evaluation, family therapy notes, psychiatric evaluation of the family and a special family evaluation done by the family consultation service at the hospital. Based upon characteristics derived from existing clinical literature and their own clinical experience, the authors listed seventy-two characteristics hypothesized to be particularly relevant in families with borderline offspring. These seventy-two items were then analyzed into eleven item groups reflecting more general characteristics, based upon the inter-item correlation matrix. The authors only took items with correlations among items within a scale. Scoring for the scales was simply the total score for the included items. Two independent raters blindly scored the families on each of the seventy-two

hypothesized characteristics, using a four point scale to rate each characteristic. Borderline families were distinguished from the other two groups by a significantly greater degree of maternal psychosis and poor rule enforcement.

In comparison with the families of paranoid schizophrenic patients, borderline patients' families were distinguished by a greater degree of maternal depression, less physical abuse between husband and wife, and less infidelity between parents. No other differences detween the BPD group and hospitalized neurotic group were noted. The authors note that a cental quality presented in their work is the neglect of the child.

Gunderson and his associates present a helpful perspective on the familial characteristics of the boderline patient. However, their study relied greatly on indices that need further validation.

## Separation and Autonomy with the BPD Family

Schwoeri and Schwoeri (1982) have stated that, "The basic conflict for the borderline patient is his/her own push for individuation and autonomy within the family under the treat of abandonment." (p.199) In many ways, the theoretical stance of a variety of psychodynamic thinkers has been reflected in the theoretical effort to

study separation and autonomy. Yet, in this area of study, we can see a widening source of influence in the borderline patient's family. Separation and autonomy are apparently not related simply to the mother-child relationship but are reflected in the patient's separation difficulties with the family unit as a whole.

The autonomy issues of borderline patients were the focus in Lobel's (1981) study on the early childhood use of transitional objects by borderline patients. The "transitional object" is a term frequently used in describing the separation and autonomy of the growing infant. Transitional objects are those items which serve to support the growing youngster's movement toward autonomy yet are a reminder of the child's attachment to the maternal figure. A "teddy bear", favorite doll or toy often serve this purpose.

Lobel hypothesized that there would be less use of transitional objects in the infancy and early childhood of borderline adolescents, in comparison to normal youngsters. In the author's study of the early family histories of twenty borderline adolescents and twenty relatively healthy adolescents, this was indeed the case. The borderline adolescents made significantly less use of transitional objects, according to the recall of the maternal figure. Lobel's study is retrospective in nature. Significant

findings should be accepted with caution in light of the potential distortions or recall problems associated with the report of the maternal figure.

The separation and autonomy issues of borderline patients was a focus of Shapiro's (1978) efforts. This author studied the families of fifty adolescents who had been diagnosed borderline personality disorder. During the course of intensive family treatment, Shapiro observed that more defensive and chaotic behavior occurred within the family of the borderline patient as certain issues were discussed. In particular, he noted that issues related to the separation and autonomy of the borderline adolescent and those associated with the adolescent's wish for nurturance were associated with poor family interaction during treatment. Retaliation and withdrawal were the primary familial reactions to the adolescent's autonomous and dependent behaviors. The lack of comparison groups and objective measurement present methodological concerns with Shapiro's work. Specifically, we are unable to determine the extent to which such familial interaction may be unique to the borderline adolescent's family milieu. However, his findings are beneficial in promoting an awareness of the apparent struggle experienced by many borderline patients in relation to autonomy and dependency needs.

Bradley (1979) suggested another perspective in her work on the relationship of early maternal separation to borderline personality in children and adolescents. Subjects for this study were drawn from three different settings; a child and adolescent department of a large inpatient psychiatric institute, a preschool day treatment center, and an assessment center for juvenile delinquents. The author utilized fourteen borderline patients and a total of sixty-eight controls. The control population included 45 psychiatric controls (12 psychotic, 33 nonpsychotic) and 23 nonpsychiatric (i.e. juvenile delinquent) controls. In this study, separation was defined as the removal of the child or lengthy absences (greater than 3-4 weeks) due to illness of the mother or caretaker. Information on the subject's separation history was drawn from chart review and interviews with case manager social workers. Results indicated that before age 5 borderline patients experienced a statistically greater number of separations than the psychotic controls, the nonpsychotic controls and the nonpsychiatrically referred delinquent controls. No significant differences were found among the groups between ages 5 and 10. The findings of Bradley et al. appear to be related to another study (Pope, Jonas, Hudson, Cohen & Gunderson, 1983) which determined that the number of adoptees was significantly greater among

subjects with BPD as compared to manic and schizophrenic subjects.

A review of those studies which have investigated the familial transactions of borderline patients indicates a variety of results. It appears that the borderline's family environment is often characterized by a debilitating transactional pattern. Conflict, lack of support and disinterest by parents, poor rule enforcement and occasional or rare family activity have been described in the findings of several studies. In addition, empirical studies have also pointed to difficulties with nomal separation and autonomy for the BPD individual. Methodological issues which limit the strength of certain conclusions are an issue in some studies. These have been addressed in the course of discussing the particular studies. Overall, we do appear to be left with a clear conclusion that the family environment of the borderline patient does not provide for normal developmental needs in the areas of both nurturance and autonomy.

Family Transmission of Borderline Personality Disorder

A second emphasis in the research on the families of borderline personality disorder patients has been on the familial transmission of this disorder. The central focus of such studies has been on the frequency with which more than one borderline personality disorder exists in a

family. In one study (Torgersen, 1983) this involved the attempt to determine a genetic component to BPD. In other empirical efforts in this area, retrospective study has observed the frequent occurrence of treatment for BPD or expression of borderline-like characteristics in the family member of the "identified patient." This area of study has not focused on the genetic or biological components to BPD but has been concerned with the social transmission of BPD within the family unit.

Genetic Transmission of BPD. Torgersen (1983) presents us with the lone empirical effort to examine the genetic issues involved in the development of borderline personality. He performed a twin study in which the sample consisted of same-sexed twins born between 1910 and 1955 who had been treated for neurotic or borderline disorders at any official in-patient and out-patient psychiatric institution in Norway before 1977. The total sample consisted of 318 twins from 299 pairs; in 19 pairs both twins had been treated for a neurotic or borderline condition.

Information on the subjects was gathered in a variety of ways; a personal interview, the Presnt State Examination (instrument used to record psychiatric symptoms), the Structured and Scaled Interview to Assess Maladjustment (used to evaluate social and family functioning) and information gained from psychiatric case

notes. Blood typing and a questionnaire addressing similarity of appearance in childhood was used as the zygosity determination (monozygotic twins have an identical genetic makeup while dyzygotic twins are genetically less similar, with 50% of their genes in common, like other siblings). Psychiatric diagnosis was made by Torgersen based upon the information gathered on the subject. Sixty-nine subjects, 47 women and 22 men were diagnosed as having schizotypal and/or borderline personality disorders. Twenty-eight of these were monozygotic twins and forty-one were dyzygotic twins. Forty-four were diagnosed as schizotypal only and ten as borderline only, fifteen were judged to have both personality disorders. A control group was formed from the remainder of the sample which matched the subjects on age at interview, sex and zygosity. Case summaries of all the twins, excluding information concerning zygosity and who was co-twin (opposite twin in the original twin pair) to whom, were independently diagnosed by two psychiatrists and the author.

The results of this study indicated that seven of twenty-one co-twins of pure schizotypal subjects were also schizotypal as compared with one of twenty-three dyzygotic co-twins (p. 02). In the pure borderline group, however, only two dyzygotic co-twins also had a

personality disorder. This conclusion suggests that biological/genetic factors are not significant in the development of BPD. As the author reports, "None of the three monozygotic co-twins of subjects with borderline personality disorder, and two of seven dyzygotic co-twins, had a borderline personality disorder. Such a result does not support a genetic etiology, but might indicate that childhood and family influences are important in the development of the disorder." (p.553)

Social Transmission of BPD. In contrast to the genetic study of BPD, another portion of the research on the family of the BPD individual has focused on the social transmission of this disorder. This study has focused more on the extent to which BPD is fostered in the family environment of the BPD individual.

Familial transmission of BPD was the emphasis of the work of Loranger, Oldham and Tulis (1982). In this study, a comparison was made of the types of mental disorder occurring in the immediate relatives of eighty-three female patients with DSM-III BPD, 100 female patients with DSM-III schizophrenia, and 100 female patients with DSM-III Bipolar disorder. This investigation included the development of an unedited transcript of all comments and references in the records concerning parents, siblings and children. Most of this information was obtained from two sources; a family

history was prepared by the patient's therapist and a social worker's summary of contact with family members. A review of this material provided evidence that 188 of the parents, siblings and children of the subjects had been treated by a physician or mental health professional for a mental disorder. The authors reviewed the records and transcripts of all available information concerning relatives who had been treated for a mental disorder, unaware of the diagnosis of the original patient and independently determined whether a relative met the criteria for schizophrenia, mania, depression or BPD.

The results of this work indicated that borderline patient's relatives were treated for more unipolar depression than the schizophrenic's relatives. In addition, in terms of the familial transmission of BPD, a finding of note was that the relative of a borderline patient was about ten times more likely to have been treated for a borderline or "borderline-like" disorder than was the relative of a schizophrenic or bipolar population, this study appears to point to the fact that BPD or borderline-like characteristics often occur with significant frequency in the family setting of the borderline patient.

Familial transmission issues of BPD were also the primary emphasis of Baron, Gruen, Asnis and Lodd (1985). These authors attempted to determine the risk for

psychiatric disorder in the immediate relatives of thirty-six subjects with schizotypal personality disorder, seventeen with borderline personality disorder and ninety normal control subjects. The subject samples were generated from a screening of 310 college students and hospital employees, "randomly recruited from local sources", and paid a nominal fee. Thus, students, were not in treatment for a psychiatric disorder at the time of the recruitment. Interviewers used an abbreviated version of the Schedule for Affective disorders and the Schedule for Interviewing Borderlines. These authors also studied 576 first generation relatives of the subjects (60 were relatives of borderline patients). Information on the relatives of the subjects was collected through two instruments; the Family History Research Diagnostic Criteria and a family history version of the Schedule for Interviewing Borderlines. In the subjects' families, the subject was the sole source of information about his or her relatives.

Based upon these sources of information, the results of this study indicated that the relatives of borderline subjects had a significantly greater risk for "definite" (5 or more DSM-III criteria for BPD) and "probable" (3 or 4 DSM-III criteria) borderline personality disorder than the relatives of normal control subjects.

The addition of a normal control group in this study

represents a significant improvement, as previous investigations had only made comparisons between individuals with a psychiatric diagnosis. However, this study does present with methodological concerns which merit a more cautious interpretation of the findings. Assessment of the relatives was not done blind to the subject's diagnosis. This obviously introduces the possibility of experimenter bias in the assessment procedure. The author's interject, however, that raters did not have a previous hypothesis regarding the "expected" family pattern. A second methodological concern with this work would be that the sample of affected subjects did not actually consist of identified patients, as they were recruited from a college community population and paid a nominal fee. We are presented with the possibility that the findings of this study are actually not comparable to a patient population. In addition, the fact that psychiatrically disturbed subjects were the sole source of family information presents us with methodological concerns discussed in previous sections of this paper. Distortions or difficulty with accurate recall limit the strength of findings in this retrospective procedure.

Danti, Adams, and Morrison (1985) provide further insight into the study of the family transmission of BPD. The target population for this study was the children of

mothers with borderline personality disorder. Mother's recruited for the project were all being treated in an intensive group-oriented day treatment program for adults with BPD. Nine children (of five mothers) ranging in age from five to seventeen years were studied. Three means of assessment were used; psychological testing, group observations and psychosocial histories. Based on this evaluation, these authors reported that all of the children had experienced serious emotional delays and exhibited disturbed behavior requiring further treatment. Rorschach findings for the children were reported as follows:

> The children were responsive to and at least somewhat disorganized by affective stimulation despite attempts to limit their experience. They all seemed to rely on similar and relatively unsophisticated defenses and coping strategies. They all relied on fantasy or withdrawal from reality rather than verbal expression in dealing with their very painful experience of the world. (p. 35)

According to these authors, and their report of the Rorschach results, the children appeared to experience significant problems in their emotional and cognitive coping. While diagnosis of the child subjects is not incorporated into this study, the findings of Danti and her associates suggest the distinct possibility of emotional and characterological difficulties in the subject sample. Yet, the findings of this study are clearly tempered by methodological limitations. The most obvious empirical

problem with this work is the lack of a control group or even comparison of assessment results with normative statistics. While the impact of the maternal relationship and family situation of these youngsters appears to be deleterious to their development, we are unable to draw such conclusions in light of the research limitations. The small sample size, both in numbers of mothers and children, also limits interpretation. The efforts of these authors point to interesting results, yet ones which require replication with larger samples and use of a control population.

A summary of those investigations which have studied the transmission issues in BPD indicates that the "identified patient" in the person of BPD individual may not be the sole family possessor of borderline, or borderline-like characteristics. In comparison with psychiatric and normal populations, the family members of borderlines have often been found to be significantly more at risk for the development of BPD. The one study (Torgersen, 1983) designed to test for a genetic component did not find an inherent biological/genetic aspect in the transmission of BPD. Other studies reviewed in this paper have observed the greater than normal occurrence of BPD in families in which one individual has been identified as BPD (Loranger et al. 1982, Baron et al. 1985). Within the current confines of the research we are left with the inability to explain this

greater than normal occurrence of BPD within a family setting as attributable to an inherent genetic pattern. At present, greater credence can be given to viewing this pattern in light of the interpersonal dynamics of the family situation. It appears that problems within the family system's structu al dynamics, e.g. poor parenting skills, difficulty with separation and autonomy, may be possible sources of the multiple occurrence of BPD. Replication is needed in this area as the several studies which have addressed transmission represent initial efforts with methodological issues impeding a full acceptance of the findings.

Psychiatric Disturbances Among Family Members

In addition to a specific focus on the prevalence of borderline conditions among the family members of diagnosed borderline individuals, further clinical research has observed the prevalence of other psychiatric disturbances among a borderline patient's family members. In light of the frequent familial patterns suggested in earlier sections of this paper, it is not surprising that a variety of psychiatric disturbances often coexist in the borderline's family.

Soloff and Millward (1983) investigated this area in their study of psychiatric disorders in the families of borderline patients. These authors compared the family

histories of psychiatric disorders in the first, second, and third generation relatives of hospitalized borderline (n=48), schizophrenic (n=42), and depressed (n=32) patients. Family histories were obtained by experienced social workers through interviews with the patients' family members and through chart review. Data were recorded in a checklist derived from the Kupfer-Detre system family history. Using this checklist, 14 categories of psychiatric disorders or symptoms were rated for the known disturbed relatives of all subjects. This retrospective effort determined that among borderline subjects, 38.3% had a first generation relative with depression. This was significantly greater than the number of first generation relatives of schizophrenics with depression (21.4%) but not distinguishable from the number of first generation relatives of depressed patients (46.9%) with depression. The impaired first generation relatives of borderline patients were also distinguished from depressed and schizophrenic control patients by the significant prevalence of "eccentric and peculiar behavior" (23.4% for borderline, 7.1% for schizophrenia, 3.1% for depressed). The term "eccentric and peculiar behavior" is from the Kuper instrument and the authors note that it is not possible to determine if the eccentricity is related to disturbances in thinking or behavior or both. In addition, controlling for multiple occurrence in the same family, seven borderline

subjects had a first generation relative who attempted suicide compared with only one depressed subject ($p < .1$). This difference warrants replication in further studies with more subjects.

In the course of their study to test the validity of the DSM-III diagnosis of BPD, Pope, Jonas, Cohen and Gunderson (1983) examined the phenomenology, family history, treatment response and 4-7 year long-term outcome of 33 patients meeting DSM-III criteria for BPD. Inpatient records were obtained and four raters examined portions of the chart while remaining blind to other portions. Rater 1 reviewed the entire hospitalization while remaining blind to family history information, treatment response and information on subsequent hospitalizations. Rater 2 assigned "probable" or "possible" diagnoses to all first generation relatives of the patient based on detailed chart information. Rater 3 rated response to psychopharmologic treatments. Rater 4 received the telephone numbers and addresses so as to permit him to contact the patients for a follow-up interview 4-7 years after the hospitalization.

Based upon this review, the authors determined that while there was an absence of schizophrenia or schizotypal personality disorder in any of the relatives, there was a relatively high prevalence of other personality disorders. Ten (7.7%) parents and siblings received the diagnosis of

histrionic, borderline or antisocial personality disorder. DSM-III major affective disorder was diagnosed in eight (6.2%) of the parents and siblings. While this study did not use a formal control population, these results were compared with those obtained in thirty-four subjects with bipolar disorder and thirty-nine schizophrenic subjects in the same hospital as identified in an earlier study. This analysis determined that histrionic, borderline and antisocial personality disorder in family members were significantly more prevalent for the family members of patients with BPD.

Finally, Stone (1977) reports on his review of seventy-two family histories gathered during ten years of private practice work. These patients were divided into three groups; 25 neurotics, 28 borderline and 15 psychotics. Stone's analysis suggested that borderline families were more apt to include at least one "ill relative" (19/28 as compared to 7/25 in the neurotic). In addition, he reported that there were four times as many "affected relatives" per patient than in the neurotic group. Stone reports the results of his investigation in a very general manner. Little or no information is provided regarding subject selection, measures used, statistical analysis or definition of terms such as "ill" and "affected." Findings should be considered in light of these significant methodological cautions.

Research investigating the existence of psychiatric disorders among the family members of borderline patient's is limited. Replication and further study with a variety of control populations appears warranted. However, based upon the current state of study, it does seem apparent that family members of borderline patients often suffer from significant affective or characterological disturbances. As with the transmission of BPD, we can note that the identified BPD individual is often not the only psychologically disturbed individual in a family. The BPD often comes from a family unit in which more than one member is significantly disturbed.

## Conclusion

Study of the BPD has been the emphasis of a variety of clinical and empirical efforts. Those interested in developmental and treatment issues associated with this disorder have pointed to the BPD individual as one who experienced serious deficits and difficulties in early development with a subsequent characterological pattern of dysfunctional thinking, affect and relationships.

The challenge of the psychotherapist to effectively work with this population suggests the need for a thorough understanding of the variety of factors involved in BPD. Part of this understanding has been generated by a fairly recent development in the clinical literature focusing on

the familial characteristics of the BPD individual. This study has provided a broader understanding of issues which impact the development of BPD.

The emphasis of the present paper has been to review and summarize the literature in this area. Three areas of focus were identified; the family transactions characteristic of the borderline family, the family transmission of BPD, and the existence of psychiatric disturbances in other members of the borderline patient's immediate family.

It may be helpful to summarize the results of studies reviewed by means of a hypothetical case study of a borderline patient. John is thirty-five year old man who presents for individual psychotherapy with concerns about problems in relationships and dealing with his feelings. During the course of early intervention with John, the therapist determines that John is diagnosed BPD. Based upon the present review, what can we hypothesize about John's family of origin?

It is likely that John's family transactions were characterized by a variety of problems. Conflict, and parental withdrawal in response to needs for support and nurturance may be characteristic of John's family pattern.

In addition, there is a clear possibility that John may not be the only member of his immediate family with

borderline or borderline-like features. While he may currently be in the role of the "identified patient" there is the strong likelihood that others in his family system experience borderline characteristics.

Finally, in a broader diagnostic sense, it is likely that John is not the only psychiatrically disturbed member of his family. There is a good possibility that at least one other member suffers from a significant affective or characterological disturbance.

The research regarding the familial characteristics of individual's with BPD suggest the benefit of those theoretical positions which have described the borderline family as a dynamic interactional unit (e.g. Mandelbaum, 1980; Schwoeri & Schwoeri, 1980). Certainly the borderline individual appears to develop within a family system in which normal developmental needs are delayed by the larger context of disturbed family interaction.

Familial characteristics highlighted in the empirical studies reviewed in this paper suggest the benefit and the need for a broader understanding in psychotherapeutic treatment. BPD has been traditionally conceptualized, particularly from the psychodynamic school, as a disturbance generated within the parent-child relationship. While research on the family characteristics of the BPD does not contradict this position, it does point to a wider source of

impact- the family unit as a whole. This significant social unit appears to play a decisive role in the development and maintenance of BPD features. In childhood, adolescence, and adulthood, the family unit of the borderline patient is clearly impactful.

This area has received surprisingly little emphasis in psychotherapy research or clinical application. The borderline individual resides within a disturbed family system. Effective psychotherapy needs to note the impact of this milieu. If individual psychotherapy is undertaken with the borderline patient, empirical study suggest the need to focus on the impact which family issues may have on the treatment progress of the client. Family treatment with the borderline patient provides the clinician with opportunity to observe in a direct manner the familial interaction and impact on the client. In addition, this form of treatment allows the therapist opportunity to intervene directly with family patterns and transactions which may be contributing to the maladjustment of the client. Suggestions for further research in this area would include study of the interface of family and individual issues in psychotherapy with borderline patients, e.g. use of family therapy as an adjunct to individual psychotherapy.

The borderline individual is certainly a challenging client. It is hoped that this review will contribute to improved understanding and treatment of this disorder.

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